

**MARYLAND COMPREHENSIVE CANCER PLAN  
BREAST CANCER SUBCOMMITTEE  
MINUTES OF THE MAY 8, 2002 MEETING**

**Attendance:**

Kathy Helzlsouer, MD, MHS, Johns Hopkins Bloomberg School of Public Health -Committee Chair

Abby Karlsen - Susan G. Komen Breast Cancer Foundation, Maryland Affiliate

Franny Lerner - Chase Brexton Health Center

Rebecca Burrett - Chase Brexton Health Center

Eric Whitacre, MD - The Breast Center at Mercy Hospital

Lorraine Tafra, MD - Anne Arundel Medical Center

Kathy Cupertino

Stanley Watkins, MD - Annapolis Medical Specialists

Renee Royak-Schaler, PhD - University of Maryland School of Medicine

Judy Destouet, MD - Advanced Radiology

Wish Martin - Sisters Surviving, Johns Hopkins Medical Institutions

Mary Sheehy, MSN, CRNP - Frederick Memorial Healthcare System

Reverend, Dr. Robert E. Steinke, Frederick Memorial Healthcare System

**DHMH Staff:**

Robert Villaneuva –Executive Director, State Council on Cancer Control

Donna Gugel - Breast and Cervical Cancer Screening Program (BCCP) Director

Kate Shockley - Comprehensive Cancer Control Coordinator

Toni Brafa-Fooksman - BCCP Coalition Coordinator

Marsha Bienia - Director, Center for Cancer Surveillance and Control

**Introductions and Committee Membership:**

Committee members and DHMH staff were introduced. Committee members were asked to review the committee membership list and make any necessary corrections. Member information, including name and organization, will be listed on the website and in the final published cancer plan. Members were given an opportunity to not have their name listed or ask questions. No members objected to the display of their information.

Donna Gugel, Program Director, for the DHMH Breast and Cervical Cancer Program distributed Breast Cancer Committee Manuals to committee members. The manual includes: a committee membership list; organizational chart for the Cancer Plan committees; a draft “Table of Contents” for the new cancer plan; copies of the chapters on breast cancer from the 1996 Maryland Cancer Plan, the Michigan Cancer Consortium Initiative, and the North Carolina Cancer Control Plan; information about breast cancer screening guidelines; and the NCI Statement on Mammography Screening.

**Overview/Evaluation**

Robert Villaneuva provided background information on the Maryland Cancer Control Plan. The original plan was written in 1991 and updated in 1996. Comprehensive cancer control is the

development of an integrated and coordinated approach to reduce the incidence, morbidity, and mortality of cancer through prevention, early detection, treatment, rehabilitation, and palliation. In September of 2001, the Maryland DHMH was awarded a 2-year cooperative agreement from the CDC to develop a Comprehensive Cancer Control Plan. Currently there are 13 states funded to implement their Comprehensive Cancer Control plans. In addition, there are 7 states funded under the Planning phase to update or rewrite their cancer plans. Past plans have been used to help formulate cancer control activities in Maryland. The new plan will discuss cancers and environmental and patient issues not addressed in earlier versions. A Core Planning Team, responsible for the initial planning and oversight of the grant, and sixteen subcommittees have been established. Subcommittees will meet 4-6 times between April and September 2002. This committee is expected to focus on racial and ethnic disparities and to formulate recommendations pertaining to the screening, diagnosis, treatment and prevention of breast cancer and the reduction of disparities. A written report from the committee is to be given to the Core Planning Team by October 1, 2002. The plan will be presented at the Cancer Council's statewide consensus conference on October 16, 2002. Seven regional town hall meetings will be held across the state between July 15 and August 15, 2002.

An Evaluation Committee was established to help guide the process by which the subcommittees operate. The evaluation committee designed an evaluation tool to be used after all subcommittee meetings. The evaluation tool uses the CIPP Evaluation Model. CIPP is the acronym for **C**ontent, **I**ntput, **P**rocess, and **P**roduct. The CIPP model is a process/satisfaction-oriented evaluation tool. Committee members are asked to complete the evaluation at the end of every meeting. The evaluation tool is available on line at <http://www.marylandcancerplan.org/evaluation.html>). The evaluation comments will be compiled and shared with committee members at the beginning of each subsequent meeting.

A Committee Member Questionnaire was passed out, and attendees were asked to list what they believe are the most important objectives for Maryland in order to decrease the burden of breast cancer and to decrease racial disparities.

Donna Gugel presented information about breast cancer programs in Maryland: The first low cost screening programs in the state were the hospital-based HSCRC programs. They were established in 1990 and ended in 1996. Through this program, twenty-six hospitals offered free clinical breast examinations and mammograms for uninsured, low-income women. Nine of these hospitals also offered pelvic examinations and Pap smears. In 1992, DHMH received a planning and implementation grant from CDC to start a statewide breast and cervical cancer screening program (BCCP). Maryland was one of the first group of 12 states to start screening patients (in late 1992). Currently CDC is funding 70 programs. County programs are funded by grants from DHMH to the local health departments. In 1996 the State legislature voted to provide state funding for breast cancer screening. This money is used to screen women 40-49 years of age.

#### **Presentation of data:**

Dr. Helzlsouer presented data on breast cancer in Maryland. A copy of Dr. Helzlsouer's presentation is included in the committee Handbook. Topics discussed included:

- Breast cancer incidence and mortality rates in Maryland
- Stage at diagnosis and five year survival rates
- Risk factors
- Breast cancer prevention and screening
- Breast Cancer Prevention Trial (BCPT, NSABP P-1)
- Mammography trials
- Current breast cancer screening issues
- The Cochrane Review
- U.S. Preventative Task Force Recommendations for Breast Cancer Screening
- PDQ Screening for Breast Cancer Summary Statement

### **Discussion/Recommendations**

- Costs/risk vs. benefits for screening - including the side effects of screening. Does screening lead to unnecessary diagnostic procedures? Why has screening increased in African American women, but survival has not increased proportionately?
- The STAR trial and the side effects of Tamoxifen.
- Current recommendations for screening.
- New technologies - The need for new screening tools and treatments to increase survival Rates.
- Should the committee propose algorithms for diagnosis and treatment? It was suggested that the committee look at the consensus statements from the American Society of Breast Surgeons and NCCN.
- The committee needs to look at motivating factors reimbursement rates, cost, for recommending /screening or treatment procedures.
- The committee should look at the reasons that some women will get screened, but do not come for or complete diagnostic and treatments procedures. Many new breast cancers are being diagnosed at very early stages, but the percentage of women diagnosed at stage 3 and 4 has not changed significantly.
- There is a need to look at which patients with DCIS should be treated for breast cancer and which patients do not need further treatment.
- Access to mammography services was discussed including the use of mobile mammography (and its drawbacks).
- The committee requested a copy of the Behavioral Risk Factor Survey. They want to know if DHMH can add any questions to the survey or whether the committee can do its own survey. Marsha Bienia mentioned that DHMH is looking into doing its own cancer -related survey and that the Breast Cancer Committee may be able to request specific questions to be included in the survey.
- Is there enough data for the committee (DHMH) to print a pamphlet on breast cancer prevention?
- The problem with the current State-funded screening program is that the money is very categorical (disease specific) and has specific age and income guidelines. Women who are under forty or diagnosed with other conditions (such as a uterine cancer) or do not meet income guidelines cannot be treated in the current programs. This issue needs to be discussed.

- Include emerging issues in the chapter.
- Determine why there is minimal mortality benefit among African American women even though screening rates have improved.
- Why is so much money spent on breast cancer research and still no major benefit, no new screening tool, no big reduction in mortality.
- Look at what California is doing with their breast cancer research money.
- What to do about DCIS? Is it a state issue or global issue? Should all DCIS be treated? Who progresses?
- Can we look at screening rates by geographic areas of mammography equipment? Looks like most radiology facilities are concentrated in the metro areas.
- How do we impart prevention message to medically underserved women (i.e. homeless women, women with substance abuse problems, etc).?
- The committee noted that although both the breast cancer incidence and mortality rates are higher in Maryland than for the United States, the difference is significantly greater for mortality. The question was raised as to what factors could be causing this. Could this be a data reporting issue? Can the committee look at this by comparing Maryland data with data from a state with a low mortality rate? Could Maryland's relatively high percentage of African American population affect the mortality rate?

#### **Data requests**

- Treatment data by region by stage, race, age
- Stage at diagnosis for 1998 & 1999
- Unstaged distribution by county
- Unstaged data: has it improved since 1997 and was it better in 1997 than 1992?
- Stage-specific data: break out local, regional and distant to specific stage and tumor size at diagnosis by region.
- Mammogram screening rates by race and insurance
- Can we look at data from community health centers and other primary health care centers to look at screening data and % of insured vs. uninsured patients?
- Need to determine how many women eligible for BCCP by county and how many screened.

The next committee meeting will be held on Tuesday, June 11, 2002 at 4 p.m. in Room L-2 at DHMH. Meetings have also been scheduled for September 10th and again on September 17th at DHMH.